



Diagnostic Center for Population and Animal Health

Phone (517) 353-1683

(see reverse side for mailing addresses)

MICHIGAN STATE
UNIVERSITY

DCPAH Case No. _____

MSU Vet. Clin. No. _____

2003 Equine Arbovirus Encephalitis

DCPAH Account No. _____

Clinic Name _____

Address _____

CITY, STATE, ZIP

Veterinarian _____

Phone () _____ Ext. _____

Cellular Phone () _____

Pager () _____

E-Mail Address _____

Owner _____

Address _____

CITY, STATE, ZIP

Day Phone () _____

Evening Phone () _____

Cellular/Pager () _____

Fax () _____

CHECK HERE: ☐ ONLY FAX RESULTS (no charge) Fax () _____
☐ ONLY HARD COPY RESULTS (no charge)
☐ BOTH FAX AND HARD COPY RESULTS (\$3/TRANSMISSION)

SPECIMEN(S) SUBMITTED

Specimen Type: ☐ CSF ☐ Blood ☐ Brain Date Specimen Taken _____

Labs other than DCPAH used for testing _____

TESTS REQUESTED

- ☐ West Nile virus encephalitis (serum or CSF testing: IgM capture ELISA or virus neutralization; brain tissue testing: histopathology and PCR and/or virus isolation for confirmation)
☐ Eastern equine encephalitis (brain tissue testing only: histopathology and immunohistochemistry, PCR and/or virus isolation for confirmation)
☐ Equine protozoal myeloencephalitis (EPM) (serum or CSF testing: Western blot analysis; brain tissue: histopathology and possibly immunohistochemistry)
☐ Other: please specify agent or disease (e.g., rabies, equine herpesvirus, etc.) _____

HORSE INFORMATION

Animal Name &/or Clinic ID _____

Breed _____ Age _____ (da. wk. mo. yr.) Sex: ☐ Male ☐ Gelding ☐ Female

CIRCLE ONE

Location Address (if different from owner address) _____

CITY, STATE, ZIP

Name of Premises/Farm _____ Barn Contact _____

Phone () _____ Fax () _____

CLINICAL SIGNS AND HISTORY

Clinical Signs (check): Date of Clinical Sign Onset _____

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Apprehension | <input type="checkbox"/> Cranial Nerve Paralysis | <input type="checkbox"/> Lameness | <input type="checkbox"/> Muscle Twitches/Fasciculations |
| <input type="checkbox"/> Head Shaking | <input type="checkbox"/> Hyperesthesia | <input type="checkbox"/> Weakness of Front Limbs | <input type="checkbox"/> Recumbency |
| <input type="checkbox"/> Ataxia/Incoordination | <input type="checkbox"/> Depression | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Aimless Wandering |
| <input type="checkbox"/> Weakness of Hind Limbs | <input type="checkbox"/> Listlessness | <input type="checkbox"/> Fever | <input type="checkbox"/> Head Pressing |

Other signs or details on above information: _____

Treatments or other management: _____

Similar or previous events: _____

Outcome and Date:

☐ Currently being treated or monitored

Date _____

☐ Recovered

Date _____

☐ Died Naturally

Date _____

☐ Euthanized

Date _____

☐ Other _____

By Whom _____

Date _____

Vaccination History:

(include **dates** for all vaccinations given in past year)

EEE/WEE _____

VNV First Vaccine _____

Booster _____

Annual Vaccine _____

Rabies _____

EPM _____

Herpes _____

Other Pertinent Information/Notes _____

FOR MDA AND LAB USE ONLY

Date Reported to MDA _____

County of equine resident for previous 2 weeks _____

Sample ID No. _____

Date Tested _____

Test Result _____

U.S. Postal Address

Diagnostic Center for Population and Animal Health
P.O. Box 30076
Lansing, MI 48909-7506

Delivery Service Address

(Weekday deliveries only)
Diagnostic Center for Population and Animal Health
B619 West Fee Hall
Michigan State University
East Lansing, MI 48824-1315

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